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Massachusetts Health Care Cost Trends

Price Variation in Health Care Services

Executive Summary

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DIVISION OF
Health Care
Finance and Policy

Introduction

Pursuant to the provisions of M.G.L. c. 118G, § 6 1/2, the Massachusetts Division of Health Care Finance and Policy (DHCFP) is required to conduct an annual study and hold public hearings regarding health care cost trends in the Commonwealth, and the factors that contribute to cost growth. During the 2010 health care cost trends hearings, many issues were raised related to price variation for health care services.[1] Purchasers, employers, and consumers noted that competition and market functionality are impeded when they are unaware of or insensitive to provider price differentials, and do not have complete price information available in choosing where to seek health care.[2] Such discussions echoed a fundamental principle established by the Special Commission on the Health Care Payment System in 2009 that differences in health care payments should reflect measurable differences in value (cost and quality) and should be transparent, including across different payers.[3] In the absence of these conditions, wide price differentials can persist, contributing to unnecessarily high health care costs.

In this report, DHCFP seeks to expand the understanding of price variation by examining prices paid by private health plans for commercially insured members in three service categories: inpatient hospital care; outpatient hospital care; and physician and other professional services.[4] In each category, a sample of high-volume health care services was selected to maximize comparability across providers. In addition, the prices paid by commercial carriers are compared to rates paid by Medicaid and Medicare. The report also analyzes the variation in the quality scores of hospitals for existing quality measures that can be directly related to the selected inpatient services. Lastly, the report explores the potential impact on health care spending of various models that reduce or eliminate the current level of price variation. These models are intended for illustrative purposes only, as estimated impacts are extrapolated for inpatient services and physician procedures based on a subset of high-volume services within these two groups.

1 See presentations and transcripts from the health care cost trends public hearings held March 2010. Available at: http://www.mass.gov/dhcfp/costtrends, accessed 5/22/2011.

2 One research study reviewing price variation noted that in some markets certain hospitals are so highly regarded that consumers perceive any health plan network that excludes these "must-have" hospitals as undesirable. In general, such hospitals can set higher prices. See: Paul B. Ginsburg, *Wide Variation in Hospital and Physician Payment Rates Evidence of Provider Market Power,* Research Brief No. 16, Center for Studying Health System Change, Washington, D.C., November 2010. Available at: http://www.hschange.org/CONTENT/1162/1162.pdf, accessed 5/22/2011.

3 The Massachusetts Special Commission on the Health Care Payment System developed a set of principles that were subsequently adapted to reflect feedback from numerous stakeholder groups, and reported in the Special Commission's final report. See: *Recommendations of the Special Commission on the Health Care Payment System*, July 16, 2009. Available at: http://www.mass.gov/Eeohhs2/docs/dhcfp/pc/Final_Report/Final_Report.pdf, accessed 5/22/2011.

4 Prices in this analysis include carrier payments as well as member copayments and deductible amounts.

The analyses in this report utilize data from five major health insurers who represent about 79 percent of the privately insured covered lives in Massachusetts and include both fully and self-insured claims for 2009. For inpatient hospital services, the data allows comparisons to be made at statewide and hospital-specific levels. For hospital outpatient and physician and other professional services, the price variation analysis was limited to the statewide level without identification of specific providers or provider groups. The analyses rely on a subset of services within each provider group to demonstrate the extent of price variation. For the inpatient analysis, the selected services represent 40 percent of all discharges and 32 percent of all private payer payments. For the physician and professional analysis, the subset of services represents 28 percent of services and 27 percent of private payer payments.[5]

A number of factors may influence the price of a medical service from provider to provider. The purpose of this report was not to enumerate the various factors that may influence price, nor to draw any potential correlations between all such factors and price. Rather, recent state law, Chapter 288 of the Acts of 2010, created a Special Commission on Provider Price Reform to further examine this issue.[6]

Key Findings

- Prices paid for the same hospital inpatient services and for physician and professional services vary significantly for every service examined. There was at least a three-fold difference for every service and for most, a variation of six- or seven-fold.
- A comparison of median prices[7] paid across hospitals reveals that for inpatient stays such as cesarean deliveries, the highest paid hospitals receive payments that are typically more than double the lowest paid hospitals. For other services such as knee and lower leg procedures, the range is significant but narrower with payment to the highest paid hospital that is 61 percent above the lowest paid hospital.
- Data on the selected 14 routine inpatient services indicates that service volume tends to be concentrated in higher paid hospitals. For example, 47 percent of vaginal deliveries occurred in the most highly paid quartile of hospitals.

5 Due to data limitations, the services analyzed for hospital outpatient services are narrower in scope and represent only 5 percent of total hospital outpatient private payer payments. Therefore, the scope of the analysis for hospital outpatient services is more limited than analyses for hospital inpatient or physician and professional services.

6 The Special Commission on Provider Price Reform is specifically charged with examining "(i) the variation in relative prices paid to providers within similar provider groups; (ii) the variation in costs of providers for services of comparable acuity, quality and complexity; (iii) the variation in volume of care provided at providers with low and high levels of relative prices or health status adjusted total medical expenses; (iv) the correlation between price paid to providers and (1) the quality of care, (2) the acuity of the patient population, (3) the provider's payor mix, (4) the provision of unique services, including specialty teaching services and community services, and (5) operational costs, including labor costs; (iii) the correlation between price paid to providers and, in the case of hospitals, status as a disproportionate share hospital, a specialty hospital, a pediatric specialty hospital or as an academic teaching hospital; and (v) policies to promote the use of providers with low health status adjusted total medical expenses." See Chapter 288 of the Acts of 2010, § 67.

7 These calculations are based on payments after adjusting for patient severity.

- In general, tertiary care hospitals were more likely to account for a higher proportion of discharges at median prices above the statewide median than community hospitals. All tertiary care hospitals received median prices that exceeded the statewide median price for chronic obstructive pulmonary disease, compared with 43 percent of community hospitals.
- There is little measurable variation among Massachusetts hospitals based on the available quality metrics related specifically to the 14 selected inpatient services. In contrast, the price variation for those services is significant, and lower priced hospitals are often associated with slightly higher quality scores and vice versa. For example, for vaginal deliveries, Milford Regional Medical Center and Tufts Medical Center have slightly higher quality scores related to deliveries, but have prices that are lower than or near the median hospital price, respectively. These results may not be surprising since carriers have previously stated that quality measures do not factor heavily in price negotiations.
- If private payer prices among hospital inpatient services and physician and professional services were narrowed to reflect a range spanning the existing 20th percentile to 80th percentile of payments, the potential total savings for these two groups of services would be about $267 million. Other scenarios such as modeling all payments at the median or just decreasing upper-end payments would yield even greater savings.
- Medicaid rates were consistently lower than the prices paid by private payers for both inpatient services and physician and professional services.[8] Private payer prices paid for physician services were also generally higher than Medicare rates, although by a lesser margin.
- There was no correlation between a hospital's share of Medicaid patients and the prices they received from private payers, with some of the lowest paid hospitals having the highest proportion of Medicaid discharges. About 70 percent of discharges for vaginal delivery at Holyoke Hospital and Cambridge Health Alliance were Medicaid patients, however these hospitals had some of the lowest private payer prices for this service, after adjusting for patient severity. This finding is inconsistent with providers' and private payers' assertions that higher private payer prices are needed to compensate for losses incurred by serving Medicaid patients.
- Medicare fee schedule rates, and to a lesser extent Medicaid, explicitly consider some of the factors cited by payers and providers that result in different prices paid across hospitals.[9] The variation associated with these factors results in a range in Medicare prices that is similar in breadth to the range found in this report's analysis of private payer prices. However, the relative rankings of hospitals are not similar across Medicare and private payers. Hospitals that receive higher payments from Medicare are not necessarily the same hospitals that receive higher payments from commercial carriers, suggesting that factors other than what Medicare considers are influencing private payer prices.

8 The only exceptions were vaginal delivery and cesarean delivery, for which some hospitals received higher payments from Medicaid than from private payers. Private payer prices were approximately 85 percent of the Medicaid prices for vaginal delivery at Boston Medical Center, Holyoke Hospital, Cambridge Health Alliance, and Martha's Vineyard Hospital.

9 For Medicare, these factors include: adjustments for area wages, indirect medical education, treating a disproportionate share of low income patients, cases that involve certain approved high cost new technologies, and high cost outliers.

Conclusion

In this report, DHCFP seeks to expand the understanding of price variation for hospitals and other professional services for a sample of health care services in three service categories: inpatient hospital care; outpatient hospital care; and physician and other professional services. These analyses are intended to promote transparency of differences in health care payments as well as inform ongoing policy discussions regarding approaches to mitigate rising health care costs. Any strategies to increase the efficiency of the Commonwealth's health care system must ensure the viability of efficient, low-cost providers in the marketplace, prioritize their role in an integrated health care delivery system, and establish them as key "building blocks" in a transition toward payment reform.

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